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SOUTH HOLLAND HOME	16300 SOUTH LOUIS AVENUE SOUTH HOLLAND, IL 60473

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S 000	Initial Comments Annual Licensure Complaint Investigations 1594113/ IL79003- Refer to 330.720 a) h) 1594086/ IL78971-330.710 a) 2), 330.1155 a)1)2)3)4), 330.1510 a) 2) b) 1) e)1) g), 330.1530 a), 330.1710 a) b) g) and 330.4240 a) 1592468/ IL77065- No Findings 1590611/ IL74749 - 330.710 a) 2), 330.1155 a) 1) 2) 3) 4), 330.1510 a) 2) b) 1) e) 1) g), 330.1530 a), 330.1710 a) b) g) and 330.4240a) 1495411/ IL73491- No Findings 1494832/ IL72871-Refer to 330.720 a) h), 330.1130 b) Incident Report Investigation IRI of 5/20/2015 / IL77382- No Findings	S 000		
S9999	Final Observations Statement of Licensure Violations 330.710a(2) 330.1155a)1)2)3)4) 330.1510a)2)b)d)(1)e)(1)g) 330.1530a) 330.1710a)b)g)	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 330.4240a) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. 2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services and social services. Section 330.1155 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 330.Appendix E. In addition, an unnecessary drug is any drug used: 1) in an excessive dose, including in duplicative therapy; 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use; or Section 330.1510 Medication Policies	S9999		

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a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility.

2) All medications taken by residents shall be ordered by the licensed prescriber directly from a pharmacy. If the facility has a licensed nurse who supervises the medication regimen of the residents, the nurse may transmit the licensed prescriber's orders to the pharmacy.

b) For the purpose of this Subpart, "licensed prescriber" means a physician; a dentist; a podiatrist; an optometrist certified to use therapeutic ocular pharmaceutical agents; a physician assistant to whom prescriptive authority has been delegated by a supervising physician; or an advanced practice nurse practicing under a valid collaborative agreement.

d) All medications on individual prescription or from the licensed prescriber's- personal supply shall be labeled as set forth in Section 330.1530(f). A licensed prescriber who dispenses medication from his or her personal office supply shall comply with Sections 33 and 54.5 of the Medical Practice Act of 1987 [225 ILCS 60/33 and 54.5]; or Section 51 of the Illinois Dental Practice Act [225 ILCS 25/51]; or the Podiatric Medical Practice Act of 1987 [225 ILCS 100]; or Section 15.1 of the Illinois Optometric Practice Act of 1987 [225 ILCS 80/15.1]; or Section 15-20 of the Nursing and Advanced Practice Nursing Act [225

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ILCS 65/15-20]; or Section 7.5 of the Physician Assistant Practice Act of 1987 [225 ILCS 95/7.5].

1) All other medications shall be authorized by a licensed prescriber for individual resident use, and shall be clearly identified with the resident's name.

e) Medication Records

1) All medications used by residents shall be recorded by facility staff at time of use. (See Section 330.1710.)

g) All medications having an expiration date that has passed, and all medications of residents who have died shall be disposed of in accordance with the written policies and procedures established by the facility in accordance with Section 330.1510. Medications shall be transferred with a resident, upon order of the resident's physician, when a resident transfers to another facility. All discontinued medications, with the exception of those products regulated and defined as controlled substances under Section 802 of the federal Controlled Substances Act (21 USC 802), shall be returned to the dispensing pharmacy. Disposition shall be noted in the resident's record.

Section 330.1530 Labeling and Storage of Medications

a) All medications shall be stored in a locked

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area at all times. Areas shall be well lighted and of sufficient size to permit storage without crowding. This area may be a drawer, cabinet, closet, or room. In those facilities where a licensed nurse dispenses medication to residents, medications may be stored in a locked mobile medication cart, which is made immobile when not in use by the nurse to dispense medication.

Section 330.1710 Resident Record Requirements

a) Each facility shall have a medical record system that retrieves information regarding individual residents.

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

g) A medication administration record shall be maintained which contains the date and time each medication is taken, name of drug, dosage, and by whom administered. A medication administration record is not required for residents who have been approved by their physician to be fully responsible for their own medications under Section 330.1510(d)(2).

Section 330.4240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or

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neglect a resident. (Section 2-107 of the Act) (A, B)

This requirement is not met as evidence by:

Based on observation, record review and interview the facility neglected to develop and implement a policy and procedures to inventory, monitor and account for resident ' s narcotics in house or used. The facility failed to follow their medication policy to ensure medications were administered in accordance with the physician ' s order and indication for use.
This failure applies to 8 of 8 residents (R1, R2, R3 R4, R5, R6, R7 and R8) reviewed for medication administration in a sample of 8.
As a result, on 2-03-15 R5 was found with a high level of opiates in the body during an emergency hospital visit and expired 2-04-15. The cause of death was determined to be related to Morphine and Hydrocodone toxicity. In addition, on 2-03-15 R1, R2, R3, R4, R6 and R7 were found by staff members with a decreased level of responsiveness. R1, R2, R3, R4, R5 and R6 were sent out for medical emergency service. Lab analysis indicated all the residents were positive for opiates in the blood.

Findings include:
According to the Facility initial investigation dated 2-3-15 on 2-3-15, (6) residents experienced a change in consciousness. Paramedics were called and residents were transported to the hospital for evaluation. The report indicates the local fire department checked the building for carbon monoxide or other possible contaminants. The incident report notes that later that day the local hospital informed the facility that the residents were screened and tested positive for

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opiates.
R5 ' s current physician order sheet noted an order for Hydrocodone/Apap 10/325 (Norco - Opiate classification) for pain as needed. R5 ' s current medication administration record notes no administration of Norco in February 2015. However, the facility provided a hand written note indicating that R5 received Norco 2-1-15 6:00 pm and Norco 2-3-15 at 12:00am. On 2-5-14 at 7:00pm E2 (Director of Nursing) said the hand written note was the facility ' s procedure to account and keep track of when R5 received Norco. A review of the note provided starts the medication count at 30 tablets dated 1-23-14 and subtracts 1 tablet after administration. The note indicates on 1-30-15 R5 Norco count was at 24, on 1-30-15 at 3:15 the count is now down to 22 tablets. E2 was unable to provide any information to account for missing tablet and the count should have been 23 after 24. E2 also said that the date of 1-23-14 was an error and should have been 1-23-15. Review of R5 ' s controlled drug receipt record /disposition form shows the form was blank. E2 said that controlled drug receipt record /disposition form is distributed by the pharmacy and the nurses should be completing this form to track and account for narcotics.
The emergency room records for R5 dated 2-3-15 and titled chemistry report was noted to be positive for opiates high level of morphine > 5000ng/ml, high level of hydrocodone detected at 477mg/ml. (Normal range is 0-100gn/ml.) R5 was noted to arrive to the emergency room unresponsive, lethargic and short of breath. The note indicates that R5 had a mental status change that is more likely secondary to the use of opioid. According to R5 ' s Death Certificate, R5 expired on 2-4-15, cause of death notes " Morphine and Hydrocodone Toxicity. " The certificate also notes describe how injury

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S9999	Continued From page 7 occurred " Inappropriate Administration of Medication by Medical Personnel. " A review of (R1 - R4, and R6) current physician order sheets dated 2-1-15 through 2-28-15 show there was no medication order or indication of use for any opiates class narcotic. A review of R7 ' s 2-1-15 through 2-28-15 physician order sheet notes an order for Norco 10/325 as needed, and Morphine sulfate 5mg sublingual every 2 hours as needed. Both of these medications are opiate class medications. A review of R7 ' s current medication administration record notes that neither medication had been administered to R7. On 2-5-15 at 4:00pm in the 4th floor medication room with E2 (Director of Nursing) R7 ' s 15ml bottle of Morphine sulfate was observed to be intact and unopened. R1 ' s emergency room record dated 2-3-15 noted R1 arrived to the emergency room unresponsive, low blood pressure. The chemistry resulted in opiates detected, a high level of morphine > 5000ng/ml. The emergency room report notes that these mental status changes could have been related to the opiate, and where the opiates came from should be investigated. R2 ' s hospital emergency room record dated 2-3-15 notes that R2 arrived to the emergency room lethargic, drowsy and basically unresponsive. The drug screen returned positive for opiates even though R2 is not listed as being on narcotics. Chemistry report detected a high level of opiates morphine > 5000ng/ml. Hospital record dated 2-3-15 noted R3 arrived to the emergency room with decreased level of responsiveness. R3 ' s reference lab detected positive for opiates, morphine noted at 31800ng/ml with a cutoff range of 0-100gn/ml. Hospital record dated 2-3-15 noted R4 arrived to the emergency room for evaluation; R4 was noted with intermittent episodes of altered mental	S9999		

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status. Unable to follow commands, opens eyes only repeated tactile stimuli. The emergency room note indicated due to pupil size it may be a narcotic overdose. Urine drug abuse panel indicates positive for opiates. Chemistry results detected high level of opiates Morphine 7700ng/ml with a cutoff range of 0-100gn/ml. R6 hospital record dated 2-3-15 indicates R6 was received in the emergency room unresponsive, though responsive to painful stimuli, short of breath, diminished breath sounds. Laboratory studies reports urine drug screen is positive for opiates. Chemistry reports detected a high level of opiate morphine > 5000ng/ml.

According to the facility ' s incident report dated 2-3-15, R7 was found to be unresponsive in his room. The hospice nurse was notified, but declined to have R7 sent to the hospital. R7 hospital drug panel 9 screen and confirmation dated 2-3-15 indicates a positive opiates serum screen. Chemistry report detected a high level of opiates morphine 5000ng/ml.

On 8-11-15 at 3:15pm Z20(Physician) said that she was made aware by the facility that an employee gave R7 an unscheduled dose of Morphine Sulfate. Z20 said after R7 was assessed and tested with a high level of Morphine. Z20 said that R7 was noted to be semi comatose after receiving the over-dose of Morphine Sulfate. Z20 said that R7's quality of life slightly changed, and a said that the change in R7's mental status may have hastened or contributed to R7's death.

On 2-5-15 at 4:00pm entering the 4th floor medication room, where refrigerated narcotics are stored for the entire facility, with E2 (Director of Nursing), there were 2 medication carts noted.

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The first cart close to the door upon entering was noted to be un-locked. The cart drawers were opened and all medications were accessible. E2 said that the carts are to be locked when not in visual control of the nurse and when in the medication room. E2 said that she would talk with the nurse on duty in regards to leaving the medication cart un-locked.
On 2-5-15 at 5:00pm along with E2 (Director of Nursing) in the 4th floor medication room an inventory of comfort packs were done to account for all the medications in the refrigerator to include Morphine Sulfate (Opiate Classification). After inventorying all comfort packs, R8 ' s comfort pack was found to be missing an entire bottle of Morphine Sulfate dosage of 20mg/ml. E2 said that she didn ' t know where the missing medication could be. E2 said that the facility didn ' t have a system in place to account for the use of narcotics. E2 said that narcotics should be accounted for each shift. E2 said that at change of shift that two (2) nurse should account for the amount of medication available at that time. E2 said that when medication is administered it is documented on medication administration record for each resident after it has been administered.
On 2-5-15 along with E2 an inventory of all (3) medication carts was done, an inventory of all medication refrigerators were completed and an inventory of R8 ' s room and medication box was inventoried. The missing vial of morphine was not located. On 2-6-15 E2 (Director of Nursing) provided an incident report dated 2-5-15 indicating the 15ml bottle of Morphine sulfate was missing and the facility could not account for it.
A review of R8 ' s clinical record medication administration record for the months of January, 2015, through February 5, 2015 documented there was no entry of administration of Morphine Sulfate. R8 ' s nursing notes for January, 2015

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through February 5, 2015 did not include any entries noting complaints of pain or administration of Morphine sulfate. The controlled drug receipt record /disposition form for Morphine Sulfate for January, 2015 through February 5, 2015 was noted to be blank.
On 2-5-15 at 6:00pm during a daily status meeting with E1 (Administrator) and E2 (Director of Nursing) both said that they didn ' t know where the missing medication could be. E2 said that the facility was not following the policy and procedure for accounting for narcotic use and destructions. E2 said that the facility should verify the amount of narcotics available by (2) nurses at change of each shift. E2 said if a resident expires or is discharged; the facility policy is to return the unused medication back to the pharmacy. E2 said that the pharmacy is not taking back unused medications so she has been using cat litter to dispose of the unused medication. E2 said if the facility disposes of the medication it should be witnessed/signed by (2) licensed nurses. E2 was unable to provide documentation to support disposal of unused medication. A review of (12) controlled drug receipt record /disposition form which denotes narcotic medication amount used delivered, amount used amount available, signature box for nurse to sign at time of administration was done. Of the (12) forms reviewed there were only (2) completed. The other (10) were noted to be blank. On 2-5-15 at 7:00pm E2 said that these forms should be completed when medication is administered and when medication is disposed.

On 3-4-15 at 11:30am E9 (Nurse) said that she was working on the morning of 2-3-15 on the 5th floor. She said that around 6:30am E21 (Certified nurse aide) reported to her that R6 was found in bed, unresponsive. E9 said that she assessed

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R6 and found her unresponsive, having difficulty breathing, increased respirations, and decreased blood pressure. E9 said that 911 were called related to respiratory distress and abnormal response.
E9 said that around 6:45am on 2-3-15 that E4 (certified nurse aide) reported to her that R7 was unresponsive. E9 said that she assessed R7 and found R7 with low blood pressure, increased respirations, shortness of breath, and low oxygen saturation. E9 said that she called the hospice nurse to alert hospice of the change of condition. E9 said that hospice nurse informed her not to call 911 for R7.
E9 said that around 6:50am E4 said that R5 was not responsive. E9 said that she assessed R5 to be slow to respond, short of breath, low blood pressure, and oxygen saturation of 70%. (Normal range: greater than 90%) E9 said that 911 were called.
E9 said a few minutes later E4 reported that R4 was unresponsive. E9 said that R4 was assessed with low blood pressure and low oxygen saturation. E9 said that paramedics were already in the building.
E9 said that E4 again reported that another resident (R1) was found to be unresponsive. E9 said that she assessed R1 to be unresponsive in bed with low blood pressure, low oxygen saturation, increased respirations and shortness of breath. E9 said that 911 were notified. E9 said that she didn ' t know what caused all of these changes in resident condition. E9 said that a total of 7 residents were found with changes in condition, but only 6 were sent to the hospital.
On 3-4-15 at 12:30pm E9 (nurse) said that prior to the incident at that occurred the morning of 2-3-15 the nursing staff were not doing narcotic counts. E9 said that she was not oriented to doing narcotic counts at this facility. E9 said that

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she asked E2 (Director of Nursing) why they weren ' t doing the counts. E9 said that E2 said we don ' t do them here. E9 said that she didn ' t know how medication was being destroyed or discarded after a resident was discharged, the medication was expired or after a pill falling on the floor. E9 said that she never destroyed any medication along with another nurse, nor had she verified narcotic counts with another nurse prior to and including 2-3-15.
On 3-4-15 at 1:00pm E18 (nurse) said that prior to the incident that occurred on 2-3-15 there was no procedure for counting narcotics. E18 said that she didn ' t verify narcotic available with another nurse at shift change. E18 said that she was not aware of inventorying the contents of the comfort kits. E18 said that prior to 2-3-15 there was no accounting for medication contained in the comfort kits.

A review the undated policy on medication administration and disposal notes: " Make sure that all medications are as ordered by the (Medical Doctor) MD " . The policy also includes when medications has been discontinued, appropriately discard all narcotics (C-Class) medications: Return to pharmacy for credit.
The facility also provided a policy on narcotic disposal. This policy indicates that all discontinued tablets or capsule narcotics should be disposed of properly by dissolving the medication in water, and once dissolved pour the mixture into a bag of cat litter and dispose in the trash. Liquid narcotics should also be poured into the mixture to be disposed of the same way. Disposal should be done and signed by (2) nurses. "
On 2-5-15 at 7:00pm E1 (Administrator), and E2 (Director of Nursing) said that the facility does not have a current policy and procedure to monitor

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and track the medications that are included in the comfort packs. Both E1/E2 said that there is no policy to inventory, monitor and account for narcotic (s) and narcotic use.
On 3-18-15 at 2:40pm Z7 (Physician/Medical Director) said that prior to 2-3-15 that she had not reviewed the facility ' s medication policies and the administration of medication policies. Z7 said that she does not develop nursing care policies. Z7 said in regards to medication administration that her expectation is that nurses would conduct themselves professionally while providing care for the residents. Z7 said that the facility should have nursing policies in place to track and account for all medications, and that no resident should receive any medications that there is no indication of use or without the medication being prescribed by their physician.

(AA)

330.720 b) h)
330.1130 b)

Section 330.720 Admission and Discharge Policies

b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care.
h) No resident shall be admitted with a communicable, contagious or infectious disease as set forth in Section 330.1130 of this Part.

Section 330.1130 Communicable Disease Policies
b) The facility shall not knowingly admit a person with a communicable, contagious, or infectious

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disease, as defined in the Control of Communicable Diseases Code. A resident who is suspected of or diagnosed as having any such disease shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 330.720 of this Part. In determining whether a transfer or discharge is necessary, the burden of proof rests on the facility.

This requirement is not met as evidenced by:

Based on observation, record review and interview the facility failed prohibit the admission or keep residents who require nursing care and the admission of a resident with an infection. This failure applies to 8 of 30 sampled residents (R6, R9, R15, R16, R17, R18, R23, R27) and 1 residents outside the sampled (R31) reviewed for admission and discharged.

Findings include:

1. R23 was a 73 year old resident with several diagnoses including CVA (cerebral vascular accident), intracranial hemorrhage, right sided hemi paresis, Dementia and type 2 Diabetes Mellitus.

The admitting nursing assessment sheet dated 4/14/15 indicates R23's mental status as alert and oriented times one. Under decubitus ulcers, the right ischium, measuring 0.2 x 0.2, superficial and deep red coccyx area. The resident service plan of care dated 4/14/15 indicates R23 needs assistance with showers, toileting, dressing,

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wheelchair, to meals and medication administered by licensed staff.

The admission orders dated 4/14/15 indicate to use Baza cream, apply to affected areas twice a day and as needed. There are no orders for treatment to the right ischium.

The Resident Functional Assessment dated 4/15/15 (completed by E13/memory care director) indicates a score of 9 in the areas of mobility, bladder, bowel bathing, personal care & grooming, dressing and medications. A score of 9 means complete assistance - the resident requires someone to perform the complete task.

The 72 hour nursing notes dated 4/21/15 (6am-2pm shift) documents the CNA (certified nurse aide) reported open area during ADL (activities of daily living). Assessment revealed sacrum/coccyx open area and eccychmotic. The physician's order dated 4/21/15 indicates to have the home health agency to evaluate wound(s) and treat.

On 8/31/15 at 1:00pm via telephone Z11 (family) stated, " the facility said they could no longer care for the bedsore, stage 4. I spoke with E25 (community liaison) who told me she (R23) needed a mechanical lift because she couldn ' t get up out of bed. A airbed and special wheelchair was needed. The staff was to change her. She used incontinent briefs and the bedpan. She needed to be turned. Staff gave her the medications. She couldn ' t take them herself. "

On 9/3/15 at 11:50am E2 (director of nursing) stated, "when it opened, she (R23) received barrier cream. When it became a stage 2, we called the home health agency. Then she started

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receiving a hydrocolloidal (dressing) every 2 days. If it fell off, the facility nurse would have put it back on."
When asked if R23 was able to set up or give herself her medications, E2 stated, " she actually took it better crushed. Yes, staff crushed her meds. Staff assisted with med administration. "

Review of the physician's orders from 4/14/15 through 5/11/15 do not show orders for a hydrocolloidal to be applied to R2's sacral/coccyx area.

The physician's order dated 4/30/15 indicates to apply wound gel, cover with gauze after cleansing as needed. The physician's order dated 5/7/15 indicates to apply wet to dry, wound gel pack, cover with (brand name) pad, cleanse with saline first.

The 72 hour nursing notes dated 5/7/15 (2pm-10pm shift) documents R2 observed with wound flapped off, presenting unstageable wound.
The physician's orders and notes dated 5/8/15 indicates R23's sacral wound measured 5.5 x 5.5 x 4.5 with undermining at 12 o'clock - 4cm, 6 o'clock-3.9, bright red skin around wound, white/gray necrotic tissue covering wound base, loosely adherent necrotic tissue in wound space, odor to wound, small amount of drainage noted.

The physician's order dated 5/11/15 indicates to send R23 to the emergency room for medical evaluation.

On 9/3/15 at 11:50am E2 stated, "I had to send her out. The pressure sore was getting worse."

The facility did not ensure that adequate and

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timely care was given to R23 as it relates to the progressive change to R23's wound to the sacral/coccyx area.

2. R31 is a 74 year old resident with several diagnoses including Dementia, acute respiratory failure with hypoxemia, COPD (chronic obstructive pulmonary disease) and dysphagia. R31 was readmitted to the facility on 8/24/15 from the hospital.

The hospital history and physical document dated 8/20/15 indicates R31 is confused and unable to take care of herself. She is confused and has severe dementia.
R31 was readmitted to the facility on 8/24/15 from the hospital.
The physician ' s order sheet has an order dated 8/25/15 to admit R31 to hospice care due to senile degeneration of the brain secondary to Dementia. R31 also has orders for Duoneb inhale 1 ampule every 4 hours as needed for congestion and oxygen 204 liters per nasal cannula as needed to keep oxygen saturations at above 90%.

On 9/1/15, R31 was noted seated in a wheelchair. R31 is alert but was not very talkative.

The Resident Functional Assessment dated 1/9/15 (completed by E13/memory care director) indicates a score of 9 in the areas of bathing, personal care & grooming, dressing and medications. A score of 9 means complete assistance - the resident requires someone to perform the complete task.

3. R9 is diagnosed with Hypertension, Dementia, Asthma and Gastric Esophageal Reflux Disease (GERD). The facility identified R9 as a hospice

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resident on a list for hospice care.

R9's Physician Certification dated 9/12/2014, says that R9 ' s level of care is Memory Care. This assessment indicated, R9 is not capable of managing her medications. R9 needs the following personal services: Eating Assistance, Dressing Assistance, Toileting Assistance, Transfer Assistance, Bathing Assistance, Personal Hygiene Assistance and Evacuating in case of emergency.

Resident Service Plan of Care dated 1/16/2015 states that R9 is mostly confused and dependent on others for activities of daily living (ADLs). This includes medication, hygiene, toileting, incontinence of bowel and bladder, dressing, eating, transferring and ambulance.

On 9/3/2015 at 9:30am, E36 (CNA) was interviewed. E36 is the direct care staff for R9. E36 stated that R9 is ' Total Care ' . R9 needs extensive physicial assistance daily for activities of daily living (ADLs). R9 is on hospice. The hospice CNA visits Mondays and Thursday for a hour to a hour and a half. The remaining time, facility staff provides care for R9.

On 9/2/15 at 11:20 AM, R9 ' s left lateral foot was observed to have a wound measuring approximately one inch long, three quarter inches wide with one quarter inch depth. Z8 (Hospice Nurse) stated the wound was initially covered with a scab, but once the scab came off, the depth was noted and has not changed. Z8 was observed to treat the wound with Medihoney and Maxorb alginate placed inside the wound bed and dry dressings and gauze roll dressing applied over the treatment. Z8 stated she provides R9 ' s treatments every Monday, Wednesday and

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Friday, but the floor nurses do any dressings if it becomes soiled or is removed by R9. Z8 stated the floor nurses will need to do the treatment on Labor Day because Z8 will be off and no routine hospice services will be done on the holiday. In response to surveyor questioning, Z8 stated she does not measure R9 ' s wound and has not spoken with facility staff to provide instruction to be sure facility staff know how to apply the Medihoney and Maxorb within the wound bed for R9 ' s wound treatment.

R9 ' s Hospice Plan of Treatment signed 8/3/15 by Z19 (Physician) includes an order that reads " [Facility] Nurse to perform wound in absence of hospice nurse. "

On 9/2/15 at 5:20 PM, E2 (Director of Nursing) acknowledged being aware of R9 ' s left foot wound and was aware of the depth, because E2 had done a dressing change two days ago when R9 removed it.

4. R15 ' s Physician Certification dated 6/9/15 indicated R15 is not capable of managing his/her medications and needs assistance with all activities of daily living. R15 ' s Resident Functional Assessment dated 5/18/15 indicates R15 needs complete physcial assistance with bathing, personal care and grooming, and dressing, is frequently incontinent, needs frequent assistance for mobility and needs occasional assistance and encouragement to eat. Hospice Notes dated 9/1/15 indicate " Patient is essentially bed bound, needs two (person) assistance to lift her up from chair to bed. "

On 9/1/15, the list of pressure ulcers provided by the facility listed R15 ' s wound as " Stage 2, Acquired. " On 9/3/15 at 11:15 AM, R15 was

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observed for wound condition and care provided by Z17 (Hospice Nurse). With the surveyor present, E6 (Certified Nurse Aide) stated to Z17 that if an aide sees that a dressing is soiled or if it falls off, they take it off and tell the nurse. R15 was noted to have a right mid-shin wound with continuous leaking of bloody serous drainage once the dressing was removed. R15 ' s right shin skin was tight and shiny, with generalized redness. Z17 initially stated the wound and skin condition were unchanged, but then added she would notify the physician regarding the skin condition. Z17 applied a hydrocolloid dressing and dry dressing covering to R15 ' s right shin wound.

R15 was transferred to bed with the physicial assistance of E6 and Z17. When R15 ' s incontinence brief was removed, no dressing was noted on R15 ' s buttocks pressure wound. The wound was approximately one inch long by one half inch wide with minimal depth, was cleansed and treated with Hydrogel and covered with a foam dressing.

On 9/3/15 at 11:30 AM, E9 (Nurse) stated the floor nurses do dressing changes as needed based on the Treatment Administration Records (TAR) and would record them on the (TAR) when done. E9 stated she was not informed that R15 ' s dressing was missing.

On 9/3/15 at 12:00 PM, E36 (Certified Nurse Aide) stated R15 ' s dressing was present on 9/1/15, but was not present as of the start of day shift on 9/3/15.

5. R27 was admitted 8/20/15. The Physician Certification dated 8/20/15 indicates R27 is " Not capable of managing his/her medications " and

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that R27 requires " Max assist " with dressing, toileting, and transfers and is " Total care " for bathing, personal hygiene and emergency evacuation. The Resident Functional Assessment dated 8/23/15 indicates R27 has " frequent challenging behaviors requiring multiple interventions " and frequent challenging behaviors including night wandering and which may require two-person assist (e.g. during personal care and PRN medications.) " R27 was admitted under Hospice care with a contract date of 5/11/15. On 9/1/15, R27 was observed during medication administration for a nebulizer treatment. R27 was not able to perform any portion of the treatment. Per E9 on 9/1/15, R27 requires continuous oxygen at four liters per minute per nasal cannula.

6. On 9/1/15, the list of pressure ulcers provided by the facility listed R6's wound as "Healing Stage 4, Admitted/Reopened ". R6's Admitting Nursing Assessment Sheet dated 3/19/15 lists R6's wound as " Pressure Ulcer Stage III " and measurements of 0.7 x 0.7 x 0.7 cm (centimeters). R6's Admitting Nurse Assessment Sheet dated 2/6/15 listed the wound as Stage 2 coccyx. On 9/2/15 at 12:10 PM, E9 stated R6 was admitted in February 2015, but was transferred out for skilled wound care and returned 3/19/15 after R6 ' s wound was debrided.

R6's Treatment Administration Record (TAR) for September 2015 reads " PRN dressing change to sacral area. No detail was noted and not notations of dressing changes were initialed in September. Home Health notes dated 8/28/15 read: " Noted pressure ulcer on coccyx measurement decrease 0.4 x 0.3 x 0.2 cm with undermining of 12 to 12 and with serous

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sanguineous. Cleanse Stage IV pressure ulcer on coccyx with normal saline solution, pack with Calcium Ag (alginate) then cover with border gauze dressing. "

On 9/3/15 at 11:50 AM, R6 was observed for wound condition and dressing status with assistance of E9 (Nurse) and E6 (Certified Nurse Aide). R6 ' s border dressing was intact to the sacral area and not dated. The dressing was partially removed to reveal a clean wound of approximately 3/8 inch diameter and 1/8 inch depth. No packing material was noted in the wound bed or in the dressing. R6's closet shelf was observed to have a box of boarder dressings and a box of Calcium Alginate sheets. On 9/3/15 at 2:00 PM, E9 stated replacement of R6's dressings would be done as needed using only the border dressing in R6's closet.

7. R16's Physician Certification 7/24/13 assesses R16 as " Not capable of managing his/her medications " and needs assistance with personal services of dressing, toileting, transfer, bathing, personal hygiene, and evacuation in case of emergency. On 9/1/15 at 10:30am, R16 sat in a reclining chair, unable to get up. R16 yelled " I can ' t get up out of my chair. " E29(Nurse Aide) stated R16 is a 2 person transfer with a gait belt and cannot transfer or toilet herself.
8. R17's Physician Certification 8/12/14 assesses R17 as needing assistance with eating, dressing, toileting, transferring, bathing, personal hygiene, and evacuation in case of an emergency. Resident Service Plan of Care 8/7/15 R17 has medications administered by licensed staff. Assessment of Physical and Psychological Needs (undated) stated R17 - health condition requires living environment that provides continual access

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to licensed and unlicensed professionals, assistance for maintenance of health and functional status, assistance is moderate to extensive. Progress Note 8/7/15 - R17 needs to use the mechanical lift at all times. On 9/1/15 at 10:40am, R17 stated staff uses the lift to transfer him to the chair and toilet. R17 cannot go to the bathroom by himself. R17 stated " I can take my own medication, they won ' t let me. "
9. R18's Physician Orders 10/23/14 R18 was admitted to the facility on contact isolation for MRSA (Methicillin Resistant Staph Aureus), with an indwelling urinary catheter. Physician Orders 10/24/14 R18 was admitted to hospice. Resident Service Plan of Care 10/27/14 R18 is dependent on others, needs to be turned every 2 hours, medications are administered by licensed staff, needs complete assistance with dressing, and assist with eating. Resident Functional Assessment 10/27/14 R18 is completely incontinent, complete assistance with bathing, grooming, personal care, and dressing. R18 has a complex medication administration, beyond the ability or desire to self medicate.

(B)

330.1510 g)
330.1530 f)
Section 330.1510 Medication Policies
g) All medications having an expiration date that has passed, and all medications of residents who have died shall be disposed of in accordance with the written policies and procedures established by the facility in accordance with Section 330.1510. Medications shall be transferred with a resident, upon order of the resident's physician, when a resident transfers to another facility. All discontinued medications, with the exception of those products regulated and defined as controlled substances under Section 802 of the

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federal Controlled Substances Act (21 USC 802), shall be returned to the dispensing pharmacy. Disposition shall be noted in the resident's record.
Section 330.1530 Labeling and Storage of Medications
f) The label of each individual medication container filled by a pharmacist shall clearly indicate the resident's full name; licensed prescriber's name; prescription number, name, strength and quantity of drug; date of issue; expiration date of all time-dated drugs; name, address, and telephone number of pharmacy issuing the drug; and the initials of the pharmacist filling the prescription. If the individual medication container is filled by a licensed prescriber from his or her own supply, the label shall clearly indicate all of the preceding information and the source of supply; it shall exclude identification of the pharmacy, pharmacist, and prescription number.
This requirement is not met as evidence by:

Based on observation, interview, and record review, the facility failed to remove expired insulin from the medication carts and label an open medication. This failure applies to two of three residents (R19, R33) reviewed during medication pass.
Findings include:
-On 9/1/15 at 1:50pm, E26 (Nurse) administered Regular Insulin to R19 from a vial marked opened on 8/3/15. On 9/2/15 at 11:50am, in the 4th floor medication office, E27(Nurse) produced 2 open vials of insulin, NPH and Regular, for R19, dated 8/3/15. These 2 vials of insulin were opened 30 days ago and not disposed as of 9/3/15. Medication Administration Record September 2015 documents R19 received doses of both types of insulin. There are no other open vials of insulin for R19.

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-On 9/1/15 at 4:05pm, E11(Nurse) administered Regular Insulin to R33 from a vial marked opened on 7/27/15. On 9/2/15 at 11:50am, in the 4th floor medication office, E27(Nurse) produced an opened vial of Regular Insulin dated 7/27/15, 37 days ago. E27 also presented an opened vial of Humulin N from R33's medication supply, out of the box, without a resident name or date opened. Medication Administration Record September 2015 documents R33 received doses of both types of insulin.
On 9/2/15 at 11:20am, E2(Director of Nursing) stated insulin vials are to be labeled with the resident' s name and the date when opened. Insulin vials expire after 28 days and should be disposed.
Medication policy revised 2/06/15 states - medications must be in the package that they were sent or picked up in.
Disposal of Medications revised 2/06/15 states- It is unsafe and unwise to keep medications that have been discontinued or are expired. Facility should destroy discontinued or expired non-controlled medications.
Medication Administration Guidelines revised 2/06/15 states - Date meds with shortened expiration dates when opened and discard expired meds. (Vials, patches, inhalers, ophthalmic, nasals, insulin, nebulizers, Lorazepam Solution).

(AW)

330.2220 a)1)d)
Section 330.2220 Housekeeping

a) Every facility shall have an effective plan for housekeeping including sufficient staff, appropriate equipment and adequate supplies. Each facility shall:
1) Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors,

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attics, basements, and storage areas.
d) All cleaning compounds, insecticides, and all other potentially hazardous compounds or agents shall be stored in locked cabinets or rooms.

This requirement is not met as evidenced by:

Based on observation, interview and record review, the facility failed to assure that hazardous items and chemicals are secured in the memory care unit. This failure has the potential to affect three of three residents (R36, R37, R38) outside the sample, identified with a wandering behavior among 30 residents on the memory care unit.

Findings include:

On 9/2/15 at 8:55 AM, E9 (staff member) identified R36, R37 and R38 as residents who are ambulatory and wander throughout the unit during the day.

On 9/1/15 at 11:00 AM on the Alzheimer's unit, a kitchenette was observed adjacent to the dining and activity room with no door or partition. The following items were observed in unlocked drawers and cabinets: a utensil tray with more than 10 forks and 10 knives, a 6.17 ounce spray can of room freshener, four nail clippers, two bottles of nail polish remover and two purses (contents unknown). E9 (Nurse) stated the purses belonged to staff and that the purses and other items should not be stored in areas accessible to the residents.

On 9/1/15 at 11:08 AM, the trash room on the Alzheimer's unit was unlocked. Inside the room was a trash chute and one of two electrical breaker boxes (right side) was unlocked, with space along the right side of the inner panel

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sufficient to allow fingers to be inserted to touch electrical wires. E17 (Maintenance Assistant) was called to the floor and freed the door latch that was stuck. E17 stated he was not sure why the lock to the breaker box was missing.
On 9/2/15 at 11:45 AM, the door to the trash room on the Alzheimer's unit was found to be unlocked and the door latch was observed to be stuck. E6 (Certified Nurse Aide) stated,
" That happens a lot. "

On 9/1/15 at 11:15 AM, Room 533 on the Alzheimer ' s unit was unlocked. E34 (Housekeeper) was inside the room, but cleaning in the outer room, which has an adjoining room. E34 stated the shower room is used as a common shower room for the floor. The shower room was observed to have a used, dry washcloth hanging over the faucet, a shaving razor on the floor, three razors in the medicine cabinet, two used toothbrushes, two used hair brushes and open containers of shampoo and deodorant. E34 stated the certified nurse aides are responsible for removing resident care items. None of the items were labeled with resident names.

On 9/2/15 at 1:50 PM, Room 533 was observed on the Environmental tour and was found to have three used toothbrushes, two used hair brushes. One of two bottles of shampoo was uncapped. One of two bottles of body wash was uncapped. Five used deodorant bottles were in the medicine cabinet. None of the items were labeled with resident names.

The facility policy, Memory Care Kitchen Area (undated) reads in part " No hazardous items are to be stored where residents may access them independently. "

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S9999	Continued From page 28 The facility policy, Environmental Hazards (undated) reads in part " All hazardous areas will be locked when staff not using these areas to prevent the residents from entering such areas. Any items that are marked as hazardous poison or may cause illness or harm to the resident will be kept in a locked area to prevent residents from accessing these items." On 9/3/15 at 10:30 AM, E1 (Administrator) stated resident care items on the Alzheimer's unit should be identified separately for each resident, brought to the shower room when needed and then secured in the resident's room for safety and infection control. ☐ (B) 330.2000 Section 330.2000 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 700). This requirement is not met as evidence by: Based on observation, interview and record review the facility failed to label opened food items in the dry and refrigerated storage area, use the mandated chemical santitation concentration in a cleaning solution for to clean food contact surfaces and ensure cookware is dried after being washed; as outlined in the Food Service Sanitation code for sections 750.130a), 750.820e)4) and 750.840 and the facility's dietary policies. This failure has the potential to affect 136 of 136 of the residents residing in the facility. Findings include: 1. On 9/1/15 at 1:50pm, during the Initial Tour of the kitchen with E32 (Food Service Supervisor), the following was noted in the walk-in freezer: -small bag of opened frozen veggies out of the	S9999		

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original packaging. Not labeled and no opened date.
-small bag of opened baby carrots out of original packaging. Not labeled and no opened date.
-a stack of eight vegetable patties, opened and out of original packaging. Not labeled and no opened date.
-one pound bag of frozen chicken, opened and out of original packaging. Not labeled and no opened date.
-one bag of chicken tenders, opened and out of original packaging. Not labeled and no opened date.
-one bag of ground chicken patties, opened and out of original packaging. Not labeled and no opened date.
-one bag of chicken drumsticks, opened and out of original packaging. Not labeled and no opened date.
-one large bag of diced meat, opened and out of original packaging. Not labeled and no opened date.
-one silver container of donuts, opened and out of original packaging. Dated 8/26/15.
-one box of chicken patties, opened and out of original packaging. Not labeled and no opened date.

E32 stated, " All items should be dated when received and dated when taken out of original packaging. We follow the Food and Sanitation Code. We know when we receive because the original box is dated. In these cases, we don ' t have the original boxes. Don ' t know how old they are. "

On 9/1/15, the following was noted in the walk-in cooler:
-one silver tray of cooked pork chops dated 8/28/15 not labeled.

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-one silver tray of cooked macaroni and cheese dated 8/25/15 not labeled.
-one silver tray of cooked meatballs dated 8/25/15 not labeled.
-one silver tray of cooked fish dated 8/13/15 not labeled.
-one large cheesecake out of original package and opened. Not dated.
-one silver pan of cooked sausage links dated 8/27/15.

E32 stated, " Prepared foods, already cooked, are good for three days. " The above items were identified by name by E32.

An undated facility policy titled, " Storage of Dry Foods & Supplies " documents: 5. Food stored outside its original package will be stored in a clean, covered container, and labeled with the common name of the food.

An undated facility policy titled, " Leftover Food " documents: PROCEDURE: 1. Label leftover foods with common name, date and time of storage. 4. Leftover foods may be stored at 41 degrees Fahrenheit in the refrigerator for up to three days and then must be discarded.

2. On 9/1/15 at 1:25pm, E38 (Dietary Aide) wiped down the food preparation table. E38 used a dish rag that was draped on the side of the sink and soaked it in a solution that was in a red bucket. E32 (Food Service Supervisor) indicated that it was a sanitation solution with a quaternary agent. At 1:40pm, E32 tested the concentration level of the sanitation solution that E38 had used to sanitize the food prep table. The concentration level of the quaternary solution: 0-100 ppm (parts per million). E32 indicated that the concentration

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of the sanitizing agent was not strong enough. E32 immediately poured out the contents of the sanitation bucket and refilled it with the premeasured quaternary solution. When retested, the concentration level was 100-200 ppm. E32 instructed E38 to re-wipe the food prep table. There was already food placed on the surface in preparation for the dinner meal.
On 9/1/15 at 1:27pm, E32 tested the concentration level of the quaternary sanitizing agent in the three compartment sink. E32 held the strip in the water for ten seconds. The color indicated that the concentration level was 0-100 ppm.
E32 stated, " It should be at 200 ppm. Right now, the sanitizing sink is weak in sanitation solution. "
Dietary staff was in the process of cleaning/rinsing/sanitizing the dishes from lunch. E32 immediately drained the sanitizing sink and refilled it with the premeasured solution up to the water line. E32 retested the concentration level: 150-200 ppm. E32 instructed the dietary staff to re-wash the pots and pans.
An undated facility policy titled, " Sanitizing Solution " documents: POLICY: Sanitizing solution buckets will be made as needed and store strategically throughout the kitchen. PURPOSE: To reduce the risk of foodborne illness via cross-contamination. PROCEDURE: 3. Quaternary ammonium solutions remain at 200 ppm.
An undated facility policy titled " Pot & Pan Washing " documents: POLICY: Manual washing will be completed by washing, rinsing and sanitizing. PURPOSE: To reduce the risk of foodborne illness. PROCEDURE: 6. Quaternary concentration 200 ppm.

3. On 9/1/15 at 1:30pm, there were twelve large silver baking pans, ten large flat cookie sheets

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S9999	Continued From page 32 and six large silver mixing bowls. These items were stored facing upwards and had pools of water in them. E32 stated, " They should be stored upside down but air dried first before placing on the rack or stored. " There were also large pots and pans that had a dried white substance on them. E32 (Food Service Supervisor) identified the white substance as water marks. E32 stated, " They were not dried before placed on the shelf so water dried and created water marks. " E32 instructed that dietary staff to remove all the affected baking pans, mixing bowl, pots and pans and re-wash them. An undated facility policy titled, " Pots & Pan Washing " documents: PURPOSE: To reduce risk of foodborne illness. PROCEDURE include: Allow items to air dry. , Store pots, pans and other items upside-down. (B) 330.4220 f) Section 330.4220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) This requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer the correct dose of sliding scale insulin to two of three residents (R19, R33) observed and reviewed during medication pass. Findings include: 1. On 9/1/15 at 1:50pm, E26(Nurse) tested R19' s blood sugar and received a result of 355. E26 drew up Regular Insulin and verified the dose of 6	S9999		

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units. E26 administered 6 units of Regular Insulin to R19.
R19's Physician Order Sheet (POS) September 2015 documents sliding scale coverage with Regular insulin as needed for a glucose reading of 351-400, 8 units.
2. On 9/1/15 at 4:05pm, R33 reported a blood sugar result of 218 to E11(Nurse). E11 drew up Regular Insulin and stated the syringe contained 2 units. The surveyor observed that the graduated marks on the syringe indicated 3 units. E11 entered R33's room with the syringe, informed R33 that the insulin was going to be administered, wiped the back of R33's left arm with an alcohol wipe, uncapped the insulin syringe, and was about to inject R33. E11 was stopped by the surveyor and rechecked the amount of insulin in the syringe. E11 verified and confirmed that the syringe contained 3 units of insulin. E11 threw away the syringe and drew up another syringe of Regular Insulin. E11 stated the syringe contained 2 units of insulin, but upon visual inspection it was verified there was 3 units of insulin in the syringe.
R33's POS September 2015 documents sliding scale coverage with Regular Insulin as needed for a glucose reading of 200-250, 2 units.
On 9/2/15 at 11:20am, E2 (Director of Nursing) reviewed and verified the correct insulin doses that should have been administered to both R19 and R33. E2 stated the insulin doses should be given as ordered.

(B)

IMPOSED PLAN OF CORRECTION

SOUTH HOLLAND HOME

DATE OF SURVEY: September 9, 2015

330.710a) 2)
330.1155a) 1)2)3)4)
330.1510a)2)b)1)e)1)g)
330.1530a)
330.1710a) b) g)
330.4240a)

Attachment B
Imposed Plan of Correction

Section 330.710 Resident Care Policies

a) The facility shall have written policies and procedures which shall be formulated with the involvement of the administrator. These written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. They shall be in compliance with the Act and all rules promulgated there under.

2) Resident care services including physician services, emergency services, personal care services, activity services, dietary services, and social services.

THIS WILL BE ACCOMPLISHED BY:

I. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding abuse, and neglect. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

A. Recognition of situations that could be interpreted as abusive or neglectful.
B. Appropriate reporting procedures for staff.
C. Appropriate and thorough investigations of alleged abuse or neglect.
D. The facility's responsibilities to prevent further potential abuse while the investigation is in progress.
E. The facility taking appropriate corrective action when an alleged violation is verified.

II. The facility will conduct MANDATORY in-services for all staff that addresses, at a minimum, the following:

A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.

C. Documentation of these In-Services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the Administrator's office.

III. The following actions will be taken to prevent re-occurrence.

A. The above In-Service Education will be reviewed with all staff on a regular basis.
B. Supervisory staff will ensure that the State Regulations regarding abuse/neglect allegations (reporting and follow-up) are followed.
C. Supervisory staff will ensure that staffs are informed of the level of care required for each resident to whom they are assigned.

IV. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding abuse, and neglect. This review will ensure that the facility's policies and procedures address, at a minimum, the following:

F. Recognition of situations that could be interpreted as abusive or neglectful.
G. Appropriate reporting procedures for staff.
H. Appropriate and thorough investigations of alleged abuse or neglect.
I. The facility's responsibilities to prevent further potential abuse while the investigation is in progress.
J. The facility taking appropriate corrective action when an alleged violation is verified.

330.1155a) 1)2)3)4) Unnecessary, Psychotropic, and Antipsychotic Drugs

a) A resident shall not be given unnecessary drugs in accordance with Section 330. Appendix E. In addition, an unnecessary drug is any drug used:

1) In an excessive dose, including in duplicative therapy;

2) For excessive duration;

3) Without adequate monitoring;

4) Without adequate indications for its use

THIS WILL BE ACCOMPLISHED BY:

I. Documentation of in-service training for unnecessary, psychotropic, and antipsychotic drugs for all nurses.

II. The Director of Nurses or her designee will monitor, and audit all psychotropic, and antipsychotic drugs on a weekly basis by using an audit tool, and is in written form. To ensure that no unnecessary, psychotropic, and antipsychotic drugs are being used. The administrator or Director of Nursing will ensure that compliance with this Imposed Plan of Correction is in compliance.

III. The Director of Nurses will conduct a written report regarding the audits to the Quality Assurance Team in the facility.

Section 330.1510 Medication Policies

a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility.

2) All medications taken by residents shall be ordered by the licensed prescriber directly from a pharmacy. If the facility has a licensed nurse who supervises the medication regimen of the residents, the nurse may transmit the licensed prescriber's orders to the pharmacy.

b) For the purpose of this Subpart, "licensed prescriber" means a physician, a dentist, a podiatrist, an optometrist certified to use therapeutic ocular pharmaceutical agents; a physician assistant to whom prescriptive authority has been delegated by a supervising physician; or an advanced practive nurse practicing under a valid collaborative agreement.

1) All other medications shall be authorized by a licensed prescriber for individual resident use, and shall be clearly identified with the resident's name.

e) Medication Records

1) All medications used by residents shall be recorded by facility staff at time of use. (See Section 330.1710)

g) All medications having an expiration date that has passed, and all medications of residents who have died shall be disposed of in accordance with the written policies and procedures established by the facility in accordance with Section 330.1510. Medications shall be transferred with a resident, upon order of the resident's physician, when a resident transfers to another facility. All discontinued

medications, with the exception of those products regulated and defined as controlled substances under Section 802 of the federal Controlled Substances Act (21 USC 802), shall be returned to the dispensing pharmacy. Disposition shall be noted in the resident's record.

THIS WILL BE ACCOMPLISHED BY:

I. The Director of Nursing will in-service all nurses of medication management policies, and procedures. Written documentation will be on file and kept in the Director of Nursing's office. The following will be included in this in -service.

1. Medication administration general guidelines;

   a. Administrating Medication

   b. Medication Record

   c. Medication Narcotic Count Sheets, to be counted with two nurses at the beginning of each shift, and at the end of each shift. These documents will be kept on file.

   d. Medication ordering and receipt by the facility staff member

   e. Medication ordering and receipt by residents, family members or responsible partied who independently manage and administer their own medications.

II. The Director of Nursing will conduct weekly audits for the next three months, then as necessary after the three month period to ensure that nurses are counting narcotics at the beginning of each shift, and the end of shift. These audits will be in written form and reported to Quality of Assurance Team meeting.

III. The facility will use cat liter, or coffee ground to dispose of all unused medications; the disposable will be done by two licensed nurses; and written documentation will be on the facilities form for destruction of narcotics, and signed off by both licensed nurses.

IV. The Director of Nursing will do a random audit two times per week to ensure compliance is being met. All audits will be documented, and available for the Department.

Section 330.1530 Labeling and Storage of Medications

a) All medications shall be stored in a locked area at all times. Areas shall be well lighted and of sufficient size to permit storage without crowding. This area may be a drawer, cabinet, closet, or room. In those facilities where a licensed nurse dispensed medication to residents, medications may be stored in a locked mobile medication care, which is made immobile when not in use by the nurse to dispense.

THIS WILL BE ACCOMPLISHED BY:

I. Medication carts, medication refrigerator that stores narcotics will be kept locked at all times; unless it is being used by the nurse, medication carts must be in visual eye of the nurse using the cart.

II. All comfort packs are opened, and reconciled upon delivery and counted on the shift to shift reporting time, and signed by two nurses.

III. All comfort packs will have their own narcotic count sheet, to be initialed by two nurses at the shift to shift reporting time.

IV. The Director of Nursing will do a random count two times a week with a nurse to reconcile all narcotics, also compared to Physician Order Sheets (POS), compared to Medication Administration Record (MAR), to ensure accuracy, the random audits will be documented on the facility audit form; and assessable to the Department upon request.

V. The Director of Nursing will give a report of these audits to the Quality Assurance Team during their meeting.

Section 330.1710 Resident Record Requirements

a) Each facility shall have a medical record system that retrieves information regarding individual residents.

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible, and, available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

g) A medication administration record shall be maintained which contains the date, and time each medication is taken, name of drug, dosage, and by whom administered. A medication administration record is not required for residents who have approval by their physicians to be fully responsible for their own medications under Section 330.1510d)2).

THIS WILL BE ACCOMPLISHED BY:

I. The Director of Nursing will conduct an in-service to all nurses based on Section 330.1710 Resident Record Requirements on Medication Administration.

II. All nurses will take a pre, and post test on Medication Administration. These test will be kept in the director of nursing's office.

III. The test will be available upon request from the Department.

Section 330.4240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2 -107 of the Act) (A, B).

THIS WILL BE ACCOMPLISHED BY:

I. The Administrator, and Director of Nursing will ensure the policy and procedures to inventory, monitor, and account for resident's narcotics in the facility.

II. The Administrator, and Director of Nursing will ensure the facility is following their medication policy to ensure medications were administered in accordance with the physicians order and indication of use.

Date of corrective action will be completed by: Ten (10) days from receipt of this notice of the Imposed Plan of Correction.